Revenue & Expenditure Report
Fiscal Year 2006 Instructions

General Instructions

1. The R&E report should reflect **RSNS'** revenues (not provider Revenues).
   a. Be sure and report the accounting method your entity uses (Full, Modified or Cash Basis).
2. The R&E report should reflect **RSNS'** expenditures (not provider Expenditures).
   a. Report expenditures associated with reported revenues
   b. Report expenditure distribution method (see page 3)
3. Refer to the *Mental Health Program BARS Supplemental* for account definitions.
4. Sample Report Format
   a. Do not change or fill in gray areas. These are formulas and will be automatically generated.
   b. Do not delete rows.
   c. Do not add rows. Attach supplemental information if you need to clarify any amounts.
   d. Do not change the overall format. Reports must be submitted in exactly the same format so that MHD can summarize and condense the information to one page (link the reports).

Revenue Section

Revenues from MHD

1. **Medicaid/Non Medicaid line:** Include MHD revenue paid under the Medicaid (Integrated) and Non-Medicaid contracts. DO NOT INCLUDE 18 MONTH ADJUSTMENTS.
   a. Medicaid capitation revenue (account code 338) and Additional Medicaid (Federal portion account code 338) revenue less estimated Medicaid utilization should be reported in the *Medicaid Funds* column.
   b. Non-Medicaid revenue (account code 334) less estimated Non-Medicaid utilization should be reported in the *Non-Medicaid Funds* column.
2. **Historical Combined line** is to report payments received from the Historical Combined payment methodology. It is reported in the *Medicaid Funds* column (for the Medicaid capitation revenue, account code 338). DO NOT INCLUDE 18 month adjustments.
3. **Integrated (Eligible) line** is to report payments received from eligible payment methodology. Medicaid capitation revenue (account code 338) and Additional Medicaid (Federal portion, account code 338) should be reported in the *Medicaid Funds* column. Non-Medicaid revenue (account code 334) should be reported in the *Non-Medicaid Funds* column. DO NOT INCLUDE 18 month adjustments.
4. **Hospital (Provided by MHD)**. This represents the amount withheld by MHD for estimated utilization (refer to the Medicaid and Non Medicaid Monthly Payment Summary Sheets). Medicaid revenue should be reported in the *Medicaid Funds* column. Non-Medicaid revenue should be reported in the *Non-Medicaid Funds* column

5. **E&T** (Provided by the RSN) is to report any revenues the RSN received from operating an E&T facility. These revenues can be reported as *Local Match Funds* (if it is used to draw down the federal match) or *Other Local Funds*. Please note: clients' sliding fee cannot be used as local match.
6. **Jail Service Proviso** is to report revenue received from providing services for mentally ill offenders confined in a county or city jail per the Non-Medicaid contract. Report in the Non-*Medicaid Funds* (account code 334) column.
7. **Incentive (Outcome Survey)** is to report the revenue received from MHD for the Incentive payment portion of the Non-Medicaid Contract. Report in the *Non-Medicaid Funds* (account code 334) column.
8. **Federal Mental Health Block Grant** is to report the Federal Block Grant *actually received* from MHD during the reporting period. It should be reported in the *Other Federal Funds* column.
9. **Crisis Integrated System Project** is to report the revenue received from MHD for the Crisis program portion of the Non-Medicaid Contract. Report in the *Non-Medicaid Funds* (account code 334) Funds column.
10. **PACE/WMIP** is to report revenue for those who have a contract with the Division and should be reported in the Medicaid *Funds* (account code 338) and Non-*Medicaid Funds* (account code 334) columns.
11. **Expanded Community Services** is to report revenue received from MHD for the Expanded Community Service portion of the Non-Medicaid contract and should be reported in the *Non-Medicaid Funds* (account code 334) column.
12. **Blended Funding** is to report the revenue under the Blended Funding Proviso for those RSNS' who have a pilot program contract with the Division. It is Medicaid revenue and should be reported in the *Medicaid Funds* column. Corresponding match must also be reported.
13. **CLIP** is to report CLIP revenue for those who have a CLIP contract with the Division.

Local

1. Maintenance of Effort is to report the local funds used to satisfy the maintenance of effort requirement per PIHP contract. It can be reported as *Local Match Funds* or *Other Local Funds*. MAINTENANCE OF EFFORT MUST BE REPORTED.
2. Other Local Funds is to report local funds other than those used to satisfy the maintenance of effort requirement. It can be reported as *Local Match Funds* or *Other Local Funds*.
   Note: You will need to report enough funds in the column *Local Match Funds* to substantiate the local match certifications you submit to the Division each biennium quarter.

Other

1. Intergovernmental is to report revenues received from government entities **other than MHD**.
2. Interest is to report interest earned on mental health funds. It is considered local funds and can be reported in the *Local Match Funds* column or *Other Local Funds* column.
3. Direct Mental Health Federal Grants is to report funds received **directly from federal sources** (not from the State of Washington) it should be reported in the *Other Federal Funds* column.
4. Other Federal Grants is to report federal grants other than Federal Block Grant **received from the State**. This includes funds received for Project for Assistance in Transition from

Homeless (PATH), and other grants targeted to support mental health services. It should be reported in the *Other Federal Funds* column.

5. Other State Grants is to report other funds received from the State. This includes funds received for DMIO and other grants targeted to support mental health services. It should be reported in the *Other State Funds* column.
6. Other Revenues is to report small revenue received on a **one-time basis**. Please describe the nature and source of this revenue in the *Details* column.

Expenditure Section

REPORT ONLY RSN EXPENDITURES. Reportable expenditures should include costs associated with reported revenues.

Report Expenditure Distribution Method: RSNS must report the method used to distribute provider reported expenditures. The following are suggested expenditure distribution procedures. (For questions, or to discuss other reasonably sound methodologies, contact Wendy Armstrong at armstws@dshs.wa.gov)

Fee-For-Service Payment Method For those RSNs who use the fee-for service payment method (and the provider reports total amount of expenses above what the RSNs actually paid) determine the RSNs actual cost by using a percentage; *allocate* between direct service costs and provider administration costs based on the percentage of provider administrative costs to total costs.

Example of Fee-for Service Payment Distribution Method:
$ *50,000 Amount RSN paid to provider* for 500 hours of individual therapy to RSN clients
$ 85,000 Actual Provider Expenses as reported by provider to RSN
$ 15,000 Total Provider Administrative expenses (as reported by provider to RSN).
$100,000 Total Expenses as reported by provider
*Based on the provider's financial statement, the provider spends 15% on administrative expenses.

RSN would report *$50,000* in expenses paid to provider as follows:
$42,500 RSN direct service costs
$ 7,500 RSN provider administrative costs
$50,000 Total Expenses paid by RSN

Block Grant, Capitation, Cost Reimbursement Method: For those RSNs who pay block grant, capitation, and cost reimbursement method, the expenditures should be allocated among the ***expenditure categories*** based on provider spending.

Example of Block Grant/Capitation/Cost Reimbursement Method:
$100,000 Amount RSN paid to provider in block grant funds from July through December 2005.
The provider spends $85,000 as follows:
$10,000 for Crisis Services
$10,000 for Freestanding E&T
$10,000 for Residential Treatment
$50,000 for Other State Plan Outpatient Treatment
$5,000 on administrative costs

The RSN should *allocate expenditures by category* paid to the provider ($100,000) on the R&E as follows:

Crisis Service	= 100,000*(10,000/85,000) = $11,764.71
Freestanding E&T	= 100,000*(10,000/85,000) = $11,764.71
Residential Treatment	= 100,000*(10,000/85,000) = $11,764.71
Other State Plan Outpatient	= 100,000*(50,000/85,000) = $58,823.53
Administrative Costs	= 100,000*(5,000/85,000) = $5,882.34

Report by Type of Service/Client and Funding Source: Please refer to the Suggested *Cost Allocation Guidelines* (attached) for acceptable cost allocation methodologies.

- *Medicaid Expenditures*. Report only those expenditures that qualify for state plan and approved B(3) (i.e., Clubhouse, Supported Employment, and Respite Care) services **provided to Medicaid enrollees** in this column.
- *Non Medicaid Expenditures* are those services (state plan and non-state plan) provided to **non-Medicaid clients or non-state plan services** provided to Medicaid enrollees.
- *FBG Expenditures* are expenditures paid by the Federal Mental Health Block Grant.
- *CLIP Expenditures* are expenditures for the Children Long Term Inpatient Program. Only those RSNs who have a CLIP contract with MHD report expenditures in this column.
- *CRF Expenditures* are the expenditures for services funded by the Community Reinvestment Fund. For services to qualify for Community Reinvestment Fund, they must be pre-approved by CMS and provided to Medicaid enrollees.

Outpatient Treatment (564.40)

Report all outpatient treatment costs in this category. (Please refer to Mental Health Division BARS Supplemental for account definitions.)

1. Crisis Services (564.41) should include crisis response costs, County Designated Mental Health Professional costs (prior to commitment) if the CDMHP also provides crisis services.
2. Freestanding Evaluation and Treatment (564.42) should include costs of providing treatment in the non-IMD (Institution for Mental Disease) E&T facilities (not including room and board costs). If your E&T facility is an IMD (Institution for Mental Disease), the expenditures need to be reported under Inpatient Treatment.
3. Mental Health Residential Treatment (564.43) should include costs of providing treatment in the residential setting. The costs should not include room and board, medical services, or custodial care. If the facility is an IMD, the expenditures are reported under Other Direct Service Costs - Residential.
4. Other State Plan Outpatient Treatment (564.44) should include costs of providing the approved state plan services not listed above, including crisis beds (stabilization services).
5. B(3) Waiver Services (564.45) should include costs of providing Supported Employment, Respite Care, and Clubhouse.
6. Other Outpatient Treatment (564.46) should include costs of providing treatment modalities other than the approved state plan modalities. These expenditures cannot be classified as Medicaid expenditures.

Other Direct Service Costs

1. Residential (564.22) should include costs of residential facilities that do not meet the state plan requirement (i.e. custodial care and IMD facilities). You can also report costs of medical services and room and board, if the RSN supplements these costs.
2. Inpatient Treatment (564.24)
   - *CLIP* should include costs of contracting with CLIP facilities for the RSNs who have CLIP contract with the Division.
   - *E&T (IMDs)* should include costs of providing services at the E&T facilities which are classified as IMDs.
   - *Hospital (Provided by MHD)* is the amount withheld by MHD for Estimated Utilization (and should equal amount report in the revenue section). Report in the *Medicaid Expenditures* and *Non Medicaid Expenditures* columns.
   - *Inpatient (18 mo Adjustment)* is to report 18-month adjustments for hospital claims. (Refer to monthly payment summary sheets for total amount.) Include Re-reconciliation (disputes resolved after 18 months) in this line. Report in the *Medicaid Expenditures* and *Non Medicaid Expenditures* columns.
   - *Liquidated Damages* is the amount withheld from the RSN by Mental Health Division for liquidated damages during the reporting period. It should be reported in the Non Medicaid column.
3. ITA Commitment Services (564.25) should include costs of CDMHP and other associated costs *excluding* judicial costs. CDMHP costs reported here can be either the whole amount (if CDMHP only does commitment services) or costs after detention (if CDMHP also responds to crisis services).
4. ITA Judicial (564.26) should include court costs for detaining clients. These costs include attorney fees, court commissioner, court clerk, petition fees, etc. These costs should be reported in the Non Medicaid column.
5. Jail Services (564.27) should include costs to provide Mental Health Services for mentally ill offenders while confined to a county or city jail. Report in the Non-Medicaid column.
6. Expanded Community Services (ECS) (564.27) should include costs to provide community support services and should be reported in the Non-Medicaid column.
7. Medicaid Personal Care (564.28) should include state funds the RSNs pay to Aging and Adult Services Administrator to provide Medicaid personal care services to clients.
8. Crisis Integrated System Program should be reported in the Non-Medicaid column.
9. Other Direct Costs (564.28) should include costs that do not fit any categories above. Explanations must be given in the Detail column.

Direct Service Support Costs (564.30)

1. Utilization Management and Quality Assurance (564.31) should include costs to ensure the adequate quality care including costs of utilization management, utilization review, costs to implement access to care standard, etc.
2. Information Services (564.32) should include costs of implementing and maintaining information system including patient tracking system, medical record staff, data lines, information system staff, and computer equipments.
3. Public Education (564.33) should include costs for consultation, education, and public information.
4. Crisis Telephone (564.35) should include costs of operating 24 hour crisis hotline.

5. Transportation (564.36) should include costs for providing transportation to clients to receive medical services including bus fare to see psychiatrist, case worker drive client to a doctor appointment, etc.
6. Interpreter Service (564.37) should include costs of providing interpreter services to clients during sessions.
7. Ombudsman (564.27) should include costs to provide an independent ombuds service.
8. Other Direct Services Support Costs (564.38) should include costs that do not fit any categories above. Explanations must be given in the Detail column.

Administrative Costs (564.10)

1. RSN Administration (564.11) should include costs of operating the RSN. Activities include planning, coordination, contracting, fiscal and contract monitoring, accounting, general clerical support, legal, facility and similar operating costs. It should also include costs allocated to the RSN from counties.
2. Provider Administration (564.12) The provider administration should include costs for general operation of direct service agencies in support of mental health service delivery such as the cost for agency administration, activities performed for program management purposes, accounting, record keeping, general clerical support, activities of the Board of Directors, and similar costs. *Costs may be allocated in part to administration according to the cost allocation plan.* Costs for administering county operated direct service agencies should be charged to this cost center.
3. Other Administrative Costs (564.13) should include costs that do not fit the above categories. Capital asset acquisition costs should also be reported here. Explanations must be given in the Detail column.

Reserves and Fund Balances

The RSN should report *current* fund balances (the final date of the R&E reporting period.) The fund balance should reflect reserves and fund **balances held at the RSN—not held at the providers**. Each category of reserves and fund balances (except risk reserve and community reinvestment fund) must be reported by fund source; capitation (Medicaid) funds, State funds, and other funds. Please note: Medicaid funds cannot be use for capital projects; and therefore should not be disclosed in Capital Reserves.

FUTURE CHANGES MAY INCLUDE IMPLEMENTATION OF CRF. Capitation fund balances left at the end of each calendar year would be transferred to the Community Reinvestment Funds (CRF) under Reserve and Fund Balances section. The CRF would be used to fund new pre-approved B (3) services for Medicaid enrollees within 1 year of the transfer. Any balance left in the CRF after 1 year is at risk and could be recouped by CMS.

Cost Allocation Guideline

RSNS must disclose the method used to determine costs for direct service, direct support service and administrative costs (*category*), and the method used to determine costs for Medicaid and Non-Medicaid funding (*fund source*).

The following examples may be used as a guideline to allocate costs by category and fund source. Other reasonably sound allocation methodologies may be acceptable. If you have questions regarding whether your allocation methodology is acceptable, please contact Wendy Armstrong, armstws@dshs.wa.gov .

Guideline for allocation of costs between direct service, direct support service, and administrative cost categories.

1. Staff Costs and Employee Benefit.
   a. Direct Care Staff – all costs of direct care staff should be charged to the appropriate direct service costs.
   b. Program Supervisors – all costs of supervisors of treatment program should be charged to the appropriate direct service costs.
   c. Management Information System Staff – all costs associated with managing patient data system (including data entry personnel who enter client service information, staffs who prepare client records, and medical record staff) should be charged to Information Services (Direct Service Support Cost).
   d. Management – management activities should be charged to Administrative Costs. These activities include meeting with local boards, agency-wide staff meetings, preparation and review of program plans and budgets, meetings with county officials, program reviews, facility planning, and any activities which do not involve direct supervision of treatment services.
   e. Administrative staff – staff assigned to support treatment programs should be charged to Other Direct Service Support Costs. Examples are billing staffs, secretarial support of clinical staff, etc. Secretarial, general clerical staff, accounting staff, budget staff, contract staff should be reported as Administrative Costs.
2. Non-Personnel Cost
   a. Facility Operations & Maintenance – the costs should be allocated based on square footage. Costs include rent, repair, maintenance, utilities, and janitorial services.
   b. Telephone – the costs should be allocated to appropriate expenditure category based upon usage. If costs cannot be tracked by usage, allocation by FTEs or staff salaries is also acceptable.
   c. Training/Travel – should be allocated based on the nature of the training/travel.
   d. Insurance – should be allocated based upon the coverage. For example, professional liability insurance should be allocated to appropriated direct service categories.
   e. Equipment – should be allocated by usage.
   f. Vehicle – should be allocated by usage.
   g. Professional Services – administrative professional services such as accounting, auditing, and legal should be charged to administrative costs. Clinical professional services such as psychiatric, clinical, treatment or program related should be charged to appropriate direct service cost centers.

h. Other – costs not specifically addressed above should be allocated by applying a reasonable measure of benefit or usage for that item.

Guideline for allocating costs between Medicaid and non Medicaid expenditure fund sources.

1. Direct Service Costs - Direct Service Costs should be allocated between Medicaid and non Medicaid expenditures based on each category of service hours submitted to Mental Health Division. Mental Health Division publishes such data on the mental health intranet web site. The address is .http://mhdintranet.mhd.dshs.wa.gov/Intranet_Documents/DataQuality/Data_Quality_Graphs.xls
   If you do not have access to the intranet, please contact your RSN IT staff.
2. Direct Support Service – some direct support categories can be tracked separately (transportation services, Interpreter Services, Crisis Telephone). If such tracking is not possible, direct service hours may be used to allocate these costs.
3. Administrative Costs – if these costs can be tracked by activity (may be through time study), please do so. Think about the following activities, which are requirements for serving Medicaid enrollees, when tracking: EQRO, BBA requirement, grievance & fair hearing process, appeal process, notice of action. If these costs cannot be tracked per activity as stated above, then allocate them based on the direct service hours.